

WELCOME



Congratulations on your recent enrollment in the Flexible Spending Arrangement plan, sponsored by **City of Seattle**. Flex-Plan Services, Inc. is here to make sure that you get the most out of this valuable benefit. We've outlined some of the administrative details of how your plan works below.

If you have general questions regarding how a Flexible Spending Arrangement plan works, you can visit our website at www.flex-plan.com, or call our customer service center. See your Summary Plan Description (available from your employer) for specific details regarding your plan.

ONLINE ACCOUNT ACCESS

Available through our website (www.flex-plan.com), select any of the links labeled 'Participant' to direct you to the participant information page. From here you can access your account by selecting 'Manage My Account'. First time users will select 'Register with Flex-Plan.com'.

To register for online account access you will be requested to provide the following information:

- Last Name, First Initial
- E-mail Address
- Company Code: **CS1**
- Choose a User Name
- Date of Birth

Do not forget to review and accept the 'Terms and Conditions'. Shortly after registering for online access you will receive an E-mail confirmation with a temporary password.

CUSTOMER SERVICE

A dedicated staff of customer service agents is available to answer your inquiries, Monday through Friday, between the hours of 7:00 am and 5:00 pm (PT). You can reach our customer service at (425) 452-3500 or toll-free at (800) 669-3539. Customer service inquiries can also be sent by E-mail to flexplan@flex-plan.com.

PLAN YEAR

The dates of service for your eligible expenses must be during the plan year, which is **January 1, 2013** through **December 31, 2013** and while you are an active participant in the plan. Any expenses incurred prior to your effective date or after your termination date cannot be reimbursed.

CLAIMS & REIMBURSEMENTS

A claim form is enclosed for your convenience. This form must be used when submitting a claim. You will want to make additional copies of the form for use throughout the year. Some other things to keep in mind:

- You may submit claims for reimbursement using one of the following methods (use only one method per submission):
 - Fax
 - Mail
 - Email
 - Online
- Submit your request for reimbursement at least two (2) full business days prior to your reimbursement date.
- For Day Care FSA claims: this benefit is not pre-funded so we can only reimburse your claim up to the balance available at the time your claim is processed.
- All claims must be submitted prior to the end of the claim filing period. Under this plan, you'll have a **90-day** claims run-out period after the end of the plan year (**March 31, 2014**) to submit claims. Claims postmarked after this date cannot be accepted.

Reimbursements will be mailed to your home or initiated to be deposited into your bank account on Wednesdays.

We are looking forward to serving you in the upcoming year.

Flex-Plan Services, Inc.

The Benny Card – Employee Overview



Your company has included the Benny Card with your benefit. You will receive two cards, each under the name of the employee participating in the plan. You will receive your card within 1-2 weeks after enrollment has been processed. Flex-Plan will reload your Benny Card with your annual election each year you elect a Benny Card. You will not receive a new card until your card expires.

Your Benny Card provides several benefits:

- ✓ Your expense is paid directly from your plan to the provider. When using your Benny Card, you will no longer have to pay for items out of pocket and wait for reimbursement.
- ✓ Only one monthly form to submit for items that require substantiation.
- ✓ Best of all, we will automatically clear copays or items purchased at participating Inventory Information Approval System (IIAS) retailers that only allow you to purchase eligible items with your card. The IIAS Participating Retailers list can be located at <http://www.flex-plan.com/news.aspx> under Benny Card Information.
- ✓ We always recommend that you **keep your receipts**.

Using your Benny Card is simple:

1. Use the Benny Card at your provider just like you would any other credit card; *do not use it as a debit card*. Be sure to save a copy of the bill, statement, invoice or receipt. This documentation must clearly show the **specific date, type and cost of service or product**. (The credit card slip alone does not contain sufficient information.)
2. Once a month you will receive an email statement containing a Benny Documentation Form. This will itemize the previous month's charges that require substantiation.
 - Any charges made in the last few days of a month may not show up on that statement.
 - If you do not use the card during a given month or if all of the charges were cleared by the copay matching system then you will not receive a statement.
3. Print out the statement and submit with documentation to Flex-Plan Services by fax, email or mail.
 - Remember, only the charges specifically listed on that claim form require substantiation and the remainder have either been cleared by our copay matching system or have not yet been posted and will show up on your next statement.
 - If you would like to see a listing of all charges made to your account, even those cleared by the copay matching system, you can view your [Online Statement](#) by visiting our website. (www.flex-plan.com)
4. In the event that there are unresolved charges after 60 days, your card will be temporarily suspended pending the substantiation of your remaining charges.

Miscellaneous Items:

- ✓ Items that are not substantiated after the completion of your plan year and claims run out period, these items may be deducted from your salary.
- ✓ The card deducts funds from your current plan only. You will not be able to access prior plan year funds with your Benny Card. To access prior plan year funds you will have to submit claims manually for reimbursement.
- ✓ If you do not re-elect for another plan year, your card will be closed. You will have to submit claims manually for reimbursement.
- ✓ There is a \$5.00 reissue fee for lost or stolen cards, and additional cards requested.
- ✓ We **ALWAYS** recommend that you keep your receipts.

Over-the-counter ("OTC") medicines and drugs are no longer eligible under an FSA or HRA unless you have a prescription from a licensed health care professional. OTC medicines or drugs include items such as Advil, Tylenol, allergy medicine, antacid, etc. You will not be able to purchase these items with your Benny™ Card. Items that are not OTC medicines or drugs (band-aid, gauze, saline solution, reading glasses etc.) are still eligible without a prescription and may be purchased with your Benny™ Card.



CITY OF SEATTLE

BENNY CARD / DIRECT DEPOSIT AUTHORIZATION FORM

Employee Information

| | | | |
|--|------------|------------------------|-----------|
| Last Name, First Name _____ | | Employee ID _____ | |
| Address _____ | City _____ | St _____ | Zip _____ |
| <input type="checkbox"/> Address Change | | | |
| Email _____ <small>REQUIRED FOR BENNY CARD ISSUANCE</small> | | DOB (MM-DD-YYYY) _____ | |

Benny Card Enrollment

IMPORTANT: The Benny™ card must be elected each year you wish to utilize it. If you used the card in the prior plan year, you will not receive a new card; your current card will be reloaded. **If you have already elected the card on the current year's enrollment form or during online enrollment then you do not need to complete this form.**

| | |
|---|--|
| <p style="text-align: center;">Benny™ FSA Debit Card</p> <p>A debit card that pays for your qualifying medical expenses from the Health Care FSA</p> | <p>There is no cost for you to receive the Benny™ Debit Card. You must provide an email address to use the Benny™ Debit Card. By checking YES I acknowledge that I have read the entire form and agree to allow my employer to deduct improper Benny Expenses from my wages.</p> |
| <input type="checkbox"/> YES, I authorize Flex-Plan Services, Inc. to issue a set of Benny™ debit cards for my Health Care FSA Benefit for this plan year. | |
| X _____ Employee Signature | _____ Date |

Direct Deposit Authorization

IMPORTANT: If your Direct Deposit information was provided when you enrolled this year, there is no need to complete this form. However, if your Direct Deposit information has changed, or if you did not provide Direct Deposit information during enrollment, use this form to elect direct deposit for reimbursements.

| | |
|---|--|
| <p style="text-align: center;">Direct Deposit</p> <p>Reimbursements are electronically deposited into your bank account.</p> | <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Checking <input type="checkbox"/> Savings </div> <div> Routing # _____ Account # _____ </div> </div> |
| <p>This authority will remain in full force and effect until Flex-Plan Services, Inc. has received written notification from me of its termination in such time and in such manner as to afford Flex-Plan Services, Inc. and the banking institution a reasonable opportunity to act on it.</p> | |
| <input type="checkbox"/> YES, I authorize Flex-Plan Services, Inc. to electronically deposit my FSA reimbursements into the above specified bank account. | |
| X _____ Employee Signature | _____ Date |

Fax completed form and documentation to:
FAX: (425) 451-7002 or toll-free (866) 535-9227

Email:
claims@flex-plan.com

Mail forms and documentation to: Flex-Plan Services, Inc.
PO Box 53250 Bellevue, WA 98015-3250

**Please read reverse for important information regarding
Direct Deposit and the Benny Card.**

Direct Deposit

Rules & Instructions

- All direct deposits will be initiated on the same day as the normal check reimbursement date. Deposits may take up to two (2) business days to appear in the designated account.
- Returned items due to incorrect banking information are assessed a \$10.00 fee.

Benny Card

Rules & Instructions

- Please be sure to include an email address above or no cards will be issued.
- You will receive two cards in the mail, both with your name on them. They may be used by yourself and/or your qualifying dependents.
- You must elect the Benny Card for each year you want to use the card. You will not receive a new card; your current card will be reloaded.
- Benny Cards are good for 5 years; at expiry you will automatically receive a new set of cards.
- Benny Cards will be loaded ONLY with the new-year annual election amount and may only be used for expenses that are incurred during the current plan year. If you have unused funds from the previous plan year or if the plan offers a Grace Period, you may not use the Benny Card to claim those funds. You will need to submit a manual claim for reimbursement.

Ineligible Benny Card Expenses

- The IRS provides the following 3 methods for correcting the reimbursement of an ineligible Benny Card Charge. A participant must: a) repay the plan for the amount of the ineligible expense, or b) request the substitution or offset of future claims to repay the plan. If neither option "a" nor "b" is successful the final option illustrated by the IRS permits the employer to deduct the ineligible expense from the participant's wages or other compensation consistent with federal and state law.
- For example, if you use the card for an ineligible expense the card will be suspended to prevent further use. We will reactivate the card once you reimburse the plan for the amount of the ineligible expense. If you do not reimburse the plan the card will remain suspended. You may still submit claims via fax or mail and, upon request, we will substitute or offset those future claims against the amount of the ineligible expense until the amount of the ineligible expense is repaid. If you do not repay the plan or substitute or offset future claims against the amount of the ineligible expense your employer may withhold the improper payment amount from your wages or other compensation consistent with applicable federal or state law.

Lost or Stolen Benny Card

- Participant will be charged \$5.00 for the reissue of any lost, stolen, or otherwise misplaced Benny Card. The fee will be deducted from the participant's Health Care FSA.

CITY OF SEATTLE

FLEXIBLE SPENDING ARRANGEMENT CLAIM FORM
FOR PLAN YEAR JANUARY 1, 2013 through DECEMBER 31, 2013

Section I – Employee Information

| | | | | | |
|---|--|------|-----------|-----|------------------------------|
| Last Name, First Name | | MI | Day Phone | | Employee ID |
| Address | | City | St | Zip | Email* SEE INFORMATION BELOW |
| <input type="checkbox"/> Address Change | | | | | |

Instructions

1. Complete Section I – Employee Information. This form can only be used for services incurred during the plan year shown above. Do not use this form for Benny™ Card transactions.
2. **Do not staple any documentation to claim form, please tape to separate sheet or include loosely in envelope. Do not send originals (all claims are stored electronically and paper copies will be shredded).**
3. Complete Section II – Day Care Claims. Attach proper third-party documentation showing the date(s) of service, cost of service, dependent's name, and provider's name and tax ID or social security number (No cancelled checks, balance forwards, or bank card receipts).
4. Complete Section III – Health Care Claims. Attach proper third-party documentation showing the date(s) of service, type(s) of service and cost (No cancelled checks, balance forwards, or bank card receipts). Itemize all expenses to prevent delays in reimbursement.
5. Complete Section IV - Signing the claim form. Fax or mail a signed claim form, but do not do both. Online claims status is available at www.flex-plan.com. Claims must be submitted at least two (2) full business days prior to the scheduled reimbursement date

Section II – Day Care FSA

| Start Date | End Date | Provider's Name, Tax ID/or SSN | Name of Dependent | Age | Cost |
|--|----------|--------------------------------|--------------------------------------|-----|------|
| | | | | | |
| | | | | | |
| | | | | | |
| See IRC Section 129 for qualifying Day Care expenses or consult your tax advisor for more information. | | | Total Day Care FSA Request \$ | | |

Section III – Health Care FSA

| Service Dates | Type of Service | Name of Provider | For Whom | Net Cost | Benny Offset? (Y/N) |
|--|-----------------|------------------|--|----------|---------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Did you use your Benny Card for any of these expenses? | | | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| See IRC Section 213 for qualifying Health Care expenses or consult a tax advisor for more information. | | | Total Health Care FSA Request \$ | | |

Section IV – Signature

To the best of my knowledge my statements on this claim form are complete and true. I understand that I am solely responsible for the sufficiency, accuracy, and veracity of claims and all information related to these claims submitted to my Health Care ("HCFSA") or Day Care Flexible Spending Arrangement ("DCFSA"), and that unless an expense for which payment or reimbursement is claimed is a proper expense under the HCFSA or DCFSA, I may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the HCFSA or DCFSA which relate to such expense. I further understand that no day care tax credit is permitted for amounts for which reimbursement is made. I am claiming health care reimbursement for eligible medical care expenses incurred by myself, spouse, and/or dependents during the plan year shown above and certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance. *By providing an email address, I consent to receive all possible communications regarding the Plan via email. I may withdraw consent at anytime without charge by contacting Flex-Plan by phone, email, or mail. To update your email address contact Flex-Plan by phone, email, or mail. You have the right to receive paper version of an electronic document free of charge. Software requirements will be provided with each electronic document. I hereby authorize my HCFSA and/or DCFSA to be reduced by the amount(s) shown above.

| | |
|---------------------------|------|
| Participant's Signature X | Date |
|---------------------------|------|

Fax completed form and documentation to:
 FAX: (425) 451-7002 or toll-free (866) 535-9227

Email:
claims@flex-plan.com

Mail forms and documentation to: Flex-Plan Services, Inc.
 PO Box 53250 Bellevue, WA 98015-3250

Customer Service Line: (425) 452-3500 or (800) 669-FLEX Visit our Web site at www.flex-plan.com